

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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International Trade Center
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COMMISSIONERS PRESENT:

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JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:

Measuring changes in input prices in traditional Medicare -- Tim Greene

P R O C E E D I N G S

MR. HACKBARTH: The first item on our agenda this morning is measuring changes in input prices in traditional Medicare. Tim, are you ready?

MR. GREENE: Good morning. I'll be speaking this morning about input price measurements used by CMS for all its different fee-for-service payment systems. I'll be focusing on measures, price indices used for adjusting for price change over time, as I'll explain.

All the payment systems operated by CMS use input price measures to determine price change. They do it for several reasons. Price indexes play two roles in prospective payment systems. First, price measurement is required to allow appropriate comparison of expenditures across geographic areas. Medicare uses measures such as wage indexes and COLA adjustments to make these comparisons. These are used for setting payments across areas.

I won't be discussing cross-sectional price measurement wage indexes at this section, but I will be focusing on the second use, which is to determine change over time in input prices paid by providers. These indexes are used both to understand provider cost change and in the process of updating payment rates.

Turning from the why to the how, an input price measurement system provides a single index number for each time period and for the group of providers for which it's defined. To get there we need to decide on three structural components of the price measure.

First, we identify and define cost categories or cost components representing the full range of items purchased by the provider and used to produce health care services. For each component we then define price proxies, or measures of price change over time. We have to use proxies generally because information on the precise prices paid by each different provider type are generally not available. However, we try and match the proxy as closely as possible to the actual component we have in mind. We'll see as we go along some cases in which this matching is done very well and others in which it's rougher.

Finally, price index or price measure is calculated as the weighted sum of price proxies for the period involved. For this we develop weights to represent the relative importance of each

cost category in hospital purchases of inputs. We base the weights on cost report or other economic information, and we recalculate them periodically over time.

Examples of cost components, by the way, might be wages and salaries paid by a hospital or the quantity of pharmaceuticals purchased by a nursing home. And we'd use price proxies such as employment cost index for civilian hospital employees for the first and a producer price index for pharmaceuticals for the latter.

I'll go over a few generic issues dealing with price measurement across sectors, then I'll turn to briefly look at the specific measures used by CMS in its payment systems. Finally I'll be going through a set of issues for each different measure and recommendation options for you to consider.

Input price indexes should represent market prices faced by providers. These may be based on the prices paid for similar inputs for providers of that type; that is, health care specific measures, or it can be based on information on prices paid in the economy overall. We call those specific or sector specific price measures or economy-wide price measures, respectively.

The former approach is desirable where we have reason to believe that the labor or product market in which the inputs are purchased is distinct from and separated from the market for the entire economy. A good example might be the wages paid for nurses or occupational therapists. The second measure, economy-wide measure, might apply where the markets from which the provider purchases are closely integrated with the economy as whole, which may include things like salaries for accountants or prices for chemicals overall.

There's a trade-off here between defining a price index. It may be more specific but it would be based on less data and less reliable data for looking at health care prices alone as opposed to economy-wide prices.

The second concern has to do with measurement of prices in a way that gives you a measure of pure price change, because some of the price measures and wage measures published by the Bureau of Labor Statistics will mix changes in price with changes in quantity. You're familiar with this in the context of the wage index in terms of occupational mix differences. We see the same thing here. Some labor costs, some average wage measures will change if wages change or if just the mix of occupations changes from higher cost to lower cost measures. That's going to be reflected in the measure that BLS will publish, and CMS will use, and that's beyond the control of CMS except in the process of choosing measures.

Finally, a crucial decision in designing a price measurement is the group of providers covered by any specific input price index. A single index could be defined for all the entire health care sector, for a broad sector such as all hospitals, or for a more narrowly defined sector such as psychiatric hospitals. Once again these are trade-offs between data availability and specificity of measurement.

Each Medicare fee-for-service program has its own unique input price index. Now as soon as I say that I have to qualify it by mentioning that several of the smaller payment systems, such as ambulatory surgery centers or labs or ambulances use broad measures like the consumer price index or various subindexes. Now those are obviously rough measures of input price change for health care sectors but they're adequate for these small cases.

However, CMS has developed and uses more refined measures for the major sectors. The first group, which we call market baskets, are indexes of the sort that I was describing earlier with cost components, price proxies, and weights, with one for every major index. The first is the input price index for PPS hospitals. This was developed by analysts at HCFA, now CMS, in the 1970s and was used for various purposes and has been used in the input inpatient PPS since its founding. It's been modified regularly, and rebased and updated, but it's still basically the same index from the '80s.

Now as you'll see, the PPS hospital input price index is sort of the mother of all price indexes, the mother of all market baskets at least. That's intended as a positive description, not the opposite.

Turning to the next, there's a separate price index for hospitals exempt from PPS. This is modeled on the PPS index, uses the same price proxies and cost categories but the weights differ slightly. So it's built on the PPS hospital market basket. It's also revised over time but it's very similar.

Third, CMS has maintained an index for skilled nursing facilities, SNFs. That has been recently revised substantially and published last July. It too is based on cost categories similar to but differing slightly from those for hospitals.

Now fourth, and here we get to a slightly different variant, CMS maintains a market basket for home health agencies. Not surprisingly, this is a much less ambitious index. While the hospital has 22 components based on 40-some price proxies, this is an index with 12 components. It's slightly different but is similar in structure but much more modest.

Now I include dialysis because it's obviously a major

sector, but CMS does not maintain any outpatient dialysis market basket at this time. The Commission staff has developed an outpatient dialysis market basket that you use for developing recommendations by piecing together pieces from components from hospital market baskets, and you recommended a year ago that CMS develop an outpatient dialysis market basket. BIPA included a mandate to do that and the agency will be reporting next July with results of its development. We look forward to seeing the results there.

Finally we have a very different sort of index that we distinguish from the market basket which is used for physician services. It's called the Medicare economic index. This was developed in 1972 in response to a congressional mandate. It differs in many ways, though it has the basic index structure, differs in many ways from the pure price indices that are reflected in the market baskets.

DR. ROWE: Is that the one that's used in the SGR?

MR. GREENE: Yes, and I'll be getting back to further discussion of it later.

Now I'll turn to cross-cutting issues affecting all the market baskets, as you'll see. This is the treatment of wages, which is typically a very important component in the market baskets. Wages and benefits account for 60 percent of the hospital market baskets and almost 80 percent of the home health market baskets. So what you decide here has a great effect on estimated cost increase over time.

First, in several ways wages can be unique to health care. First, the examples I was giving earlier, we have many groups of employees such as nurses, occupational therapists, who are unique to various health care sectors and whose labor markets can differ greatly. As you know, there have been shortages in many of these occupations, in particular registered nurses in the last year, so we'll see wage developments there that will differ greatly from those in the economy as a whole.

Secondly -- and this is specific to areas such as hospitals -- we now see changes in historical patterns in wage growth in the PPS hospital sector that's considerably faster than wage growth in the economy as a whole. To again to view health care as different in that way.

I note managed care pressure and payer pressure because historically CMS and other analysts had been averse to basing market basket change on wage indexes for the provider group alone for fear that by making estimated cost change based on behavior of a particular group of providers you could validate and roll forward price and wage setting by that group. The standard

concern was, if you use hospital wages to set the hospital market basket, hospitals can, by their own behavior, increase their market basket over time.

That may have been a concern 15 years ago in a context of considerable private sector activity. We think the concern about unwarranted wage setting in matters like this is history. We don't need to worry about that in choosing wage proxies.

However, we do have several choices to be made in deciding about the wage proxies to use. First, as I indicated, we have to choose between economy-wide measures, or measures for the entire health care sector, or measures specific to any given sector. These could be wages and salaries of service occupations in the economy as a whole in the first case, or there are employment cost indexes for health service workers in general, or thirdly, you could have civilian hospital employees as an example of one that would be particular to a specific sector.

But even after we make those choices, or given those choices, we have to make a choice between the level of definition whether we're looking at health care specific occupations or general labor categories. Again, general labor categories may allow you to be more specific in terms of a type of occupation, but health care specific occupations may be broader but specific to health care.

An example of the first might be computer programmers and the latter might be nurses. What you'd like most would be a measure of hospital computer programmers, but wage series like that don't exist. So again we've got to make choices and make trade-offs in defining indexes.

We've put together some recommendation options in this area. I'll read the more precise language. The Secretary should explore use of more appropriate wage and benefit proxies in all input price indexes. Measures should be as specific to each sector and each sector's labor categories as possible. This addresses the question of appropriate match of proxy with category that I mentioned at the beginning as well as the choice of labor category that I was just discussing.

I don't know how you wish to approach these. Discuss them now --

MR. HACKBARTH: Go all the way through.

MR. GREENE: Fine. PPS-exempt hospital market basket is, as I say, very similar to the PPS market basket. As currently defined it covers a wide range of sectors: psychiatric hospitals, rehabilitation hospitals, units and so on. However, we believe that these individual sectors or subsectors may differ both in input mix, use of nurses, LPNs and so on, as well as cost trends.

That leads us to recommend that as it develops and introduces prospective payment systems for psychiatric, long term, and rehabilitation hospitals and units, the Secretary should consider developing separate input price indexes for them as soon as possible. This we think is a real concern now because the payment systems are changing from a TEFRA-based basically reimbursement system to prospective payment systems for each.

CMS expressed interest in the idea of developing separate indexes for these sectors when it last revised the excluded hospital market basket in 1996. But as far as I know there's no activity going on in this area.

DR. ROWE: Might I ask a clarification?

MR. GREENE: Certainly.

DR. ROWE: What do you mean by long term? I think it's a non-specific term.

MR. GREENE: It's a category of hospitals, long term care hospitals.

DR. ROWE: Are those chronic care hospitals?

MR. GREENE: Yes.

DR. KAPLAN: Average length of stay is 25 days.

DR. ROWE: And they're called long term care? I thought they were called chronic care hospitals.

DR. KAPLAN: No, they're called long term care hospitals.

DR. ROWE: So that's what you're referring to?

MR. GREENE: Yes.

DR. ROWE: As opposed to long term care, which could be --

MR. GREENE: No. It's a very specific statutory category.

Finally, on the Medicare economic index. MEI differs from the market baskets and from most pure price indexes by including an adjustment for productivity change before the final index number is calculated. A measure of productivity change in the overall economy is calculated. A 10-year moving average of that measure is developed and higher productivity, growth in the general economy is used to reduce growth in the MEI.

We note that a pure price index such as the consumer price index or the hospital market basket doesn't make adjustments for productivity change like this. We do note that as in the hospital market basket or in decisionmaking in general, you may wish to consider the effects of productivity growth in deciding on -- making an update decision. But you may not want to include it as part of the pure price index of the sort that we're talking today.

Second, MEI proxies are not a good match for the components. There's a component for physician time which is represented by a wage and a benefit index. But the wages and benefit indexes are

for non-farm production workers in the economy as a whole. We think that's a poor variable to measure change in physician salaries and benefits.

Third, because the index currently uses a measure called average hourly earnings for production workers to proxy physician wages, salaries and benefits it's sensitive to changes in input mix. Occupational changes in the data measured by the average hourly earnings index can increase its value just as changes in wages paid to those employees will increase its value.

Finally, as used in the current SGR system, the MEI is calculated retrospectively, historically. Unlike the market baskets which use forecasts calculated by a HCFA contractor, the MEI uses historical data. You recommended in the past that this be changed, and you could repeat that recommendation or note it.

We put together some recommendation options for the MEI that address the major issues I was just discussing. We say, the Secretary should modify the Medicare economic index by using more appropriate measures of wages and salaries and of benefits for physicians than those used in the current index. There are not physician-specific price series that we're thinking of but certainly things more precise, more appropriate than average hourly earnings for production workers.

Secondly, we think that productivity should be handled differently than it is in the MEI. We emphasize that productivity can be considered, should be considered in an update framework but it should not be included as part of a pure price index such as a market basket or the MEI.

Do you wish to discuss these now or do you want to come back to them later? I'm done with my presentation.

MR. HACKBARTH: I think we ought to discuss them.

DR. REISCHAUER: When I was reading this I felt a desire for magnitudes. I wanted to know what's the nature of the problem in terms of size that we're dealing with. I thought with respect to all these different measures that we have, if I went 1995 to 2000 how much do these differ, the SNF one versus the PPS --

MR. GREENE: I'm not sure.

DR. REISCHAUER: -- in the growth over that kind of period?

MR. GREENE: Exempt hospitals and PPS hospitals are very --

DR. REISCHAUER: That's one kind of metric to show how much variability there is now and maybe we're devoting a lot of resources to something that doesn't make a whole heck of a lot of difference.

MR. GREENE: You mean whether you could make do with one index across the board?

DR. REISCHAUER: Yes, right. Then there's the other issue

which is you're talking about some refinements, that this component is a pretty poor proxy for what we really want to get at. Just illustrating that, the example being the production worker income in hourly pay versus you could take the AMA average physician earnings over a five or a 10-year period. Just to give some kind of flavor for what we're dealing with here.

MR. GREENE: I don't know the comparison of those series. For example, comparing the exempt hospitals and the PPS hospitals index you get, looking at the weights --

DR. REISCHAUER: But you're talking about changing weights not about changing anything else. I don't know -- probably the weights offset each other.

MR. GREENE: The exempt and PPS market baskets are very similar but the labor weight is 2 percent higher in one, 2.5 percent, and pharmaceutical weights is going to be 1 percent lower in the exempt market basket.

DR. REISCHAUER: Just one thing. I presumed in the text you were talking about percentage points, not percent.

MR. GREENE: Yes, things that sum to one. Yes, percentage points.

DR. NEWHOUSE: I thought the major changes here were probably on the MEI, and I agreed with Tim's proposals. I would also say to Bob, I think the point is well taken, some of the changes, as we just said, could be changes in weights which are essentially costless to make, and there's a certain element to face validity to some of the changes as well. But I have no problems with the recommendations.

MR. SMITH: I'm not sure I do either, Tim. But for instance, the production worker wage relationship to physician income sounds screwy. But because it sounds screwy doesn't mean it is screwy. I wonder, what do we know that tells us that this is an inappropriate reference? Is there other data? You've come to the conclusion that it's inappropriate but if you get below the surface it's not obvious that it is. I just wonder what else we know that would help us think about whether or not investing a lot of money or time in trying to find a different index is going to get us a different outcome.

MR. GREENE: We're not talking about developing new data. Typically we're talking about looking at existing BLS indexes and considering things, wages and salaries of professional and technical workers, things that seem to match the concept better. We're not talking about a major costly and time-consuming effort. We're talking about --

MR. SMITH: I'm just wondering if we've looked at that, if we've looked at some other data available in the wage series,

compared it to the AMA data and had seen whether or not it would make any difference if we shifted, or what the orders of magnitude of the difference would be.

DR. NEWHOUSE: The professional series, on the web site at least, only starts in '97 though and goes through '99, so it's hard to know.

MR. GREENE: That's the sort of thing -- for example, in the exempt hospital recommendation we're suggesting that CMS dig into this data and dig into the issues we're talking about. Apart from the MEI we are talking about basically technical recommendations, it's true. These are not major changes. Or possibly the exempt hospitals is a bigger change; separate indexes.

DR. LOOP: Could you explain the productivity adjustment to me a little bit, because it says on page 12, in the absence of reliable methods of measuring it, MedPAC assumes that productivity and technology offset each other, leading to no net increase or decrease of cost. To me that's a pretty big assumption. There's a lot of new technologies that don't make medicine more productive I would think. Could you just explain productivity to me?

MR. GREENE: That's a description of the way we put together our decisionmaking for the overall update framework, which is not the market basket per se but it's background and relevant to how you treat productivity within the market basket.

We've worked for years in ProPAC and now MedPAC to develop acceptable productivity measures for individual sectors without success, as well as investing a good deal of time, effort, and consultant time into developing measures of scientific and technological change costs. In that sense we haven't been able to develop two series there that are strong enough that we're comfortable with using them separately.

DR. ROWE: When this was discussed yesterday by the staff, balancing productivity and technology, as a proxy for productivity you used reduction in length of stay, as I heard yesterday.

MR. GREENE: Yes.

DR. ROWE: That that was an increase in productivity, a reduction in length of stay per average discharge, and that the savings associated with that were expected to be balanced out by the increased cost of technology. That's what I thought I heard yesterday in one of the discussions. Is that relevant to this?

MR. GREENE: Yes.

MR. ASHBY: If I could make a comment on that since you're quoting me from yesterday. I think it's better to suggest that

productivity and length of stay decline overlap but are not the same. Because the trouble we have always had with length of stay decline is that it represents a combination of real productivity improvements, or at least declines in resources used per stay, but that it also represents a shift of care from the acute setting to other settings. Given that we have to pay for care in those other settings that sort of cancels out any possibility of productivity improvement for that part of it.

But it's clearly a mixture of both. And I have to add to our list of frustrations that Tim talked about. We tried to separate the two and measure that and were pretty much unsuccessful. So we know that it's both, we just can't tell you the proportions very accurately.

DR. ROSS: Let me just add an addendum to that too, which is they're not synonymous. We would expect productivity growth in all of these different sectors even where we don't have a length of stay analog. In the physician settings you can imagine the use of the Internet or web-based diagnostic techniques would surely have to have increased productivity; you know, faster than flipping through the Merck manual or something like that.

DR. NEWHOUSE: Also the productivity change in the physician sector is likely variable by specialty.

DR. ROWE: I agree with all of this. I just thought I heard yesterday, increases in productivity, for instance, as reflected in reductions in length of stay, we expect to be more or less balanced out by -- I thought that's what I heard. So I was just asking whether that was the proxy or whether it's a piece of it. It's obviously a piece of it.

DR. ROSS: That was, in part, also just stating a philosophy that this commission and its predecessor commissions have adopted in terms of a 0.5 percent on productivity versus increase in S&TA. You're going to have to make a judgment on the physician side about what you believe are the impacts of increasing technological advances and how much do you want to finance, so to speak, out of productivity growth versus acknowledge through higher payments.

MR. GREENE: Consideration of productivity here is almost a negative consideration. As opposed to laying out the entire update framework, we're concerned about the inclusion of it in the measure that should be a pure price measure rather than one that reflects a variety of factors affecting output costs: productivity, input price change, and so on.

In a sense, a MEI historically and even as it exists today was not designed and isn't a measure of pure price change like the CPI is. The inclusion of productivity is only the most

dramatic way in which it's more of an overall payment-setting measure, which is, in a sense, the way it was originally designed in 1972, rather than a pure price measure as the market baskets, designed later for different uses, are.

DR. ROSS: I just wanted to make a technical response to Bob and David's concerns about the faux precision in all of this. There's some truth to that concern and in fact if the Congress -- if MedPAC followed its new approach of assessing payment accuracy, and allowing errors to offset, and did a good job of it, and made the recommendation every year and the Congress faithfully followed through on what MedPAC recommended, then you might be concerned about doing too much refinement on these narrow price indexes.

But in fact if you let -- if for whatever reason payments flow from a market basket over a several year period, small divergences can move lots of money. In the hospital sector they're moving billions of dollars.

The second thing is, Bob, a lot of the divergences, the long run is pretty long for differences in trends. If you look at comparisons of wage growth between the hospital sector and economy-wide, they diverge for six or seven years. They've now swung in a different direction. So they don't balance out necessarily over a short period.

MS. RAPHAEL: My question was in line with what Murray just said, because our first recommendation is to explore. We want the Secretary, I presume, to explore the use of more appropriate wage and benefit proxies, et cetera. My question was, explore seems very tepid. If this is a serious issue -- and that's why I had a question about magnitude also. If this is a serious issue and we believe that the current proxies and measures, et cetera, are seriously deficient than we ought to have something that is a more forceful recommendation. If it's not a serious issue then I question whether or not we ought to do anything.

MR. HACKBARTH: Along those same lines, Tim, what would CMS say, if whoever does this at CMS were sitting right next to you? If these are, in many cases, costless changes and they potentially, at least in the long run, could have serious implications, why haven't they done it?

MR. GREENE: First, as I indicated -- well, if there's someone from CMS to speak they may be able to give you a better response. Many were here yesterday, a number of people, and I thought a few were here.

But first, they certainly are conducting continuing technical analyses of market basket information and every five years or so revise them and update the data and update the

categories and change definitions. To some extent we're emphasizing the matter such as matching wage measures more closely to categories that I'm sure they've considered and may or may not agree on. In some areas, as with the exempt hospital example, we know from their 1996 statements they are considering establishing separate market baskets for the subcategories. So that's the answer there.

The third, on the MEI is a larger policy issue.

MR. HACKBARTH: Clearly the MEI is a different animal altogether. But as Carol says, these questions presumably have been clear to them, just as they are clear to you, and we say something as tepid as, the Secretary ought to explore, Secretary Thompson isn't going to do this in his office. He's going to just hand it to the people who haven't been doing it in the past.

MR. GREENE: That's just the conventional way of framing this, as you know.

MR. HACKBARTH: I know, but if you really think it needs to be changed you'd probably have to say something more forceful than, the Secretary should explore.

DR. NEWHOUSE: Do we know the answer to how much difference it would make? I'm not sure we know.

MR. SMITH: But then it's not clear we ought to recommend -- I do feel that this is a case where being data free is really a huge liability. I just don't know, Joe. If it doesn't make a big difference, then the Secretary has got better things to do. If it does, we ought to --

DR. NEWHOUSE: But I don't think we know that it doesn't make a big difference.

MR. SMITH: But we don't know that it does either.

DR. NEWHOUSE: Right. But we ought to find out.

MR. SMITH: We ought to find out before we recommend --

DR. REISCHAUER: Jack knows. He's standing up.

MR. ASHBY: There is one thing that we do know, and that is that on the issue of the wage proxies we have separate indicators available from BLS that allow us to run this with hospital wages and to run it with economy wages. Over the last seven or eight years the difference has been huge; just a tremendous amount of money has changed hands over that. For a number of years the disparity went in favor of the hospital industry. But then as the labor shortages starting emerging in the last year or two, there was a knee-jerk reaction in the other direction and the favor went rather significantly to the government side.

So there's a lot of money that we know is involved in that and we're not really suggesting that we want to produce more or less money to the hospital industry. We really just want to get

it right because, after all, we don't really know what's going to become of the labor shortage issue. It's kind of subdued at the moment but if it emerges again next year it would be nice to have an automatic reaction to it which is what this recommendation would facilitate.

DR. REISCHAUER: Having a little illustrative table in this that brings this out I think would strengthen the whole analysis tremendously.

MR. ASHBY: That we can do for next time.

DR. ROSS: Just to follow up on Jack's point, because on that first recommendation option, those two bullets, the first one is in many ways a policy call even more than a technical call and what do you think the appropriate weights are to think about this market; look at nationwide versus the hospital sector.

The second bullet is dropping down now to outpatient services, home care, and SNF and there, one reason why nothing has been done is that this wasn't all that relevant in a pre-PPS world.

MR. HEFFLER: I thought I'd try to help clarify some of these issues although I'm not sure I want to do this, but I'll give it a shot here.

MR. HACKBARTH: Why don't you go ahead and introduce yourself.

MR. HEFFLER: Sure. Steve Heffler from CMS and the Office of the Actuary. I would say specifically about the recommendation on the wage and benefit, if you want to focus on nursing home, for instance, right now a nursing home uses the ECI, or the SNF market basket uses the ECI for nursing homes. So right there you have a wage proxy that is reflective of that industry.

On the hospital side, the hospital wage and benefit proxy is a weighted average of occupations in the hospital. The only difference in an internal hospital measure and the measure that's used is that instead of using the ECI for hospital we do this occupational weighting of ECI, and the occupational mix is a fixed mix of occupations in a hospital.

My guess -- and I will try to answer the question -- we do look at this. We do try to answer these questions, try to address these issues. There are changes over time in the labor markets, and the pressures, and the wage pressures, and the shortages and so forth, and keep an eye on that. But generally I think over a period of time you're not talking about huge differences in what the total market basket would be.

Now the wage is the biggest share, but we're essentially weighting occupations in the hospital in that fixed mix and we

think using the ECI, when we compare the ECI hospital to our occupational mix the differences are not that large. Even though in a given short period of time you can have health wages moving faster or slower than overall wages, it doesn't tend to have a large effect on the market basket. So I don't know if that helps clarify that issue.

Speaking to Glenn's point, this is something we're constantly monitoring and measuring. We do keep an eye on it, and every time we rebase we address these same issues, sometimes when we feel that the index is not picking up what it should be picking up, or is not reflective of what is going on. We rebase more often than a five-year schedule. But each time we do rebase we try to address these same, these issues that have been raised here, and explore these. Whether the Secretary tells us to do it or not, we do try to address these issues.

The last thing that I would say about the impact of this is, all these updates are set prospectively. They're forecast. So historically you can have some differences in health wages versus non-health wages. But when you're looking at forecast you don't always have -- those differences over time, they tend to narrow when you're looking in a forecast. There's generally not tremendous forecasted differences between the two unless there would be something like a nursing shortage or something like that that was going to cause a major difference in the two series.

So I guess in conclusion I would say that from our research we found that changing the wage proxies, while having a bigger effect than changing the proxy from a smaller part of the market basket, generally would not have a large top-side impact on the overall market basket.

MR. HACKBARTH: Thank you. Two more comments then we need to bring this to a conclusion.

DR. NELSON: We're going to drill down on physician productivity in the future, I understand that. But I think it will be really important for us to begin with assumptions that aren't possibly false. For example, that e-mail has increased physician productivity. Almost certainly it has not increased the proportion of services for which a physician gets paid as a factor of total work.

Likewise, coding requirements. Compliance plans are often now instructing physicians to put diagnostic codes on themselves, so they're having to learn new coding requirements and documentation requirements. Certainly increases the amount of work without increasing the amount of paid work.

What I'm saying is, we've used ludicrously suspect numbers for productivity in the past, and as we go forward it will be

important for us to have some evidence beyond the assumptions as we explore that factor.

DR. LOOP: In reading this I note that the hospital market basket is revised at five-year intervals. I just wanted to formalize this question. We've touched around it here in this discussion, but it seems to me that the pace of medicine is accelerating all the time and you've got IT issues, bioterrorism, labor shortages, innovations with increasing frequency. Is this five-year interval really practical today or do the analysts believe that five years -- there's not much changes in five years? I mean, just labor costs alone in the hospital industry have risen between 9 and 18 percent in the past year.

MR. GREENE: Price/wage changes like that are going to be reflected in the annual data. It's the relative importance that will matter less. Even there -- and this gets to be a technical point -- as something becomes relatively more important, even on a year by year basis, its weight in the market basket will increase even between these rebasing periods. If pharmaceuticals are increasing in price more rapidly than other items, they become relatively more important even in a time between rebasing.

I think it's also a question of availability of data. Some of the economic data that CMS will use for revisions and rebasing is not available on an annual basis. As Steve just mentioned, when it appears to be appropriate they will revise more frequently than every five years.

DR. NEWHOUSE: There is some evidence on this. We did a study of input price index for treating heart attacks. It showed rebasing made, as I recall, about a percentage point difference per year over rebasing every five years. It was a substantial difference.

MR. HACKBARTH: Okay, I think we're done for today on this. We'll actually take up the formal recommendations and voting in January when we meet.